CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 16.7
TITLE: PODIATRY

AUTHORITY: 38 CFR 17.270 and 17.272(a)(25)

RELATED AUTHORITY: 32 CFR 199.4(c)(2) and (g)(31)

I. EFFECTIVE DATE

September 20, 1990

II. PROCEDURE CODE(S)

11000-11001, 11730-11765, and 28290

III. DESCRIPTION

Podiatry applies to services provided by doctors of Podiatry or surgical Chiropody. It is the specialized field that deals with the study and care of the foot, including its anatomy, pathology, medical and surgical treatment (including the ankle and lower extremity in some states).

IV. POLICY

A. Podiatry or surgical chiropody services are covered if considered medically necessary, effective, and reasonable treatment for the patient's diagnosis and condition; if performed by a licensed podiatrist (must be licensed in the state in which practicing) and practicing within the scope of the state license; and if the services and the patient's condition require the judgment, knowledge, and skills of a qualified provider of podiatry services because of their complexity and sophistication.

B. Podiatric services and related services, such as laboratory and radiology services, are covered.

C. Routine Foot Care. Routine foot care services are considered medically necessary for peripheral vascular disease, metabolic or neurological disease.

V. POLICY CONSIDERATIONS

A. Toenail Surgery (CPT codes 11730-11765). Partial or total removal of a toenail by surgical or chemical means is covered for distorted nails and infections to include onychomycosis (mycotic nails), onychauxis (club nails), onychogryphosis (deformed nails) or onychocryptosis (ingrown toenail). Removal of medial and lateral (tibial and fibular) borders is considered an integral part of the procedure and not reimbursable as a separate procedure. The local anesthetic is considered an integral part of the toenail surgery and is not eligible for coverage as a separate procedure.

B. Local Anesthesia. Therapeutic nerve blocks, including somatic nerve blocks, are considered part of the global fee for the surgical procedure and are not eligible for separate reimbursement.

C. Laser Surgery. Laser surgery is commonly used for ingrown toenails and verruca removal. Reimbursement for use of the laser shall not exceed the reimbursement for the standard surgical procedure (see Chapter 2, Section 29.8, *Laser Surgery*).

D. Pre and Post-Op Care. Normal pre and post-op care are included in the global surgical fee.

E. Multiple Surgery Procedures. When multiple surgical procedures are performed during the same operative session, benefits shall be limited to the lesser of the total billed charge or the sum of 100 percent of the prevailing charge for the major surgical procedure (defined as that procedure for which the prevailing charge is greatest) and 50 percent of the prevailing charge for the other procedures. If the multiple surgical procedures involve the toes, benefits for the third and subsequent procedures are to be limited to 25 percent of the prevailing charge. No reimbursement is to be made for an incidental procedure unless it is required for surgical management of multiple traumas or if it involves a major body system different from the primary surgical service.

F. Procedure with Several Components. A procedure that is comprised of several components (for example, a bunionectomy with sesamoidectomy – CPT code 28290) is to be reimbursed according to the CPT code for the all-inclusive procedure. The associated procedures are integral to the primary procedure and are not eligible for coverage as separate procedures. A sesamoidectomy is a covered service only when not performed in conjunction with other foot surgery.

G. Hammertoe surgery, flat feet conditions, bunionectomy, subungual ostectomy, tendon-lengthening procedures, (see Chapter 2, Section 19.1, *Musculoskeletal System)*.

H. Debridement and whirlpool treatment (CPT codes 11000-11001). Whirlpool treatment is an integral part of the debridement procedure and is included in the amount allowed under the debridement profile. If billed separately, the services should be combined and the allowable charge for the debridement paid.

I. Bilateral procedures. A bilateral procedure (both feet) is treated as a multiple surgical procedure consisting of a primary and secondary procedure. Bilateral procedure code profiles should reimburse at 1-1/2 times the unilateral profile.

J. Assistant surgeon. A Podiatrist may function as an assistant surgeon, but payment can only be made in those cases when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident or other house physician. Services of nonauthorized providers or house staff surgical assistants are not eligible for coverage. Such assistants are usually part of the podiatry office or hospital staff and their services are considered an integral part of the surgical fee. An assistant surgeon is not routinely required for bilateral procedures (see Chapter 2, Section 29.2, *Assistant Surgeons*).

K. Injections and aspiration of joints. Payment for injections and aspiration of joints is to be made under the policy for Musculoskeletal System (see Chapter 2, Section 19.1, *Musculoskeletal System*).

L. Non-invasive Vascular Diagnostic Studies.

1. Cerebrovascular arterial studies (codes 93875-93888). These studies, in conjunction with podiatry services, are not medically appropriate and are not covered. See cerebrovascular arterial studies in Chapter 2, Section 34.2, *Non-Invasive Peripheral Vascular Diagnostic Studies*.

2. Other Vascular Studies.

a. Bilateral comparison studies are not medically necessary when unilateral surgery is performed.

b. Preoperative studies without medical indication is not medically necessary.

c. The arterial study alone provides sufficient information for the treating podiatrist. Multiple studies on the same date of service are not generally considered medically necessary and should be reviewed to determine appropriateness.

d. Preoperative non-invasive arterial and venous vascular studies may be covered if the patient has non-palpable pulses and exhibits three or more of the following symptoms: decreased hair growth in the extremity, nail changes, abnormal skin texture, abnormal skin color/temperature, and/or pigmentation change.

e. Preoperative non-invasive arterial and venous vascular studies are covered to evaluate the following conditions:

(1.) arteriosclerosis obliterans,

(2.) Buerger's disease,

(3.) chronic hypertension,

(4.) diabetes mellitus,

(5.) gangrene,

(6.) intermittent claudication or ischemic type pain,

(7.) non-traumatic amputation of the foot or any part thereof, and

(8.) peripheral vascular disease.

M. Laboratory services. Laboratory procedures are covered only when medically necessary and related specifically to the diagnosis.

N. Radiology services.

1. Pre- and post-op films are covered only when invasive procedures are to be performed. Only one post-operative film is considered medically necessary and only when covered bone surgery is performed. More than one should be reviewed to determine if the unique circumstances of the case established the appropriateness of any additional film(s).

Note: Other radiology services are generally not considered medically necessary and are not covered. Any such claim should be reviewed for medical necessity.

2. A pattern of pre- and post-op x-rays associated with soft tissue surgery from a particular provider or provider group should alert the reviewer to request documentation as to medical necessity.

3. A pattern of claims for x-rays for suspected foreign bodies should alert the reviewer to request documentation from the provider as to whether a radiopaque foreign body has been located and removed.

O. Office Surgery. When podiatry surgery is performed in the office of the individual professional provider, no separate charges are authorized for a treatment room or recovery room nurses. These charges are normal overhead expenses and are considered to be included within the determined allowable amount for the service rendered. No additional amount is authorized.

VI. EXCLUSIONS

A. Removal of corns, calluses trimming of toenails, and other routine podiatry services, unless the patient has a diagnosed systemic medical disease affecting the lower limbs.

B. Nerve blocks performed for the theoretical purpose of increasing blood supply to the foot and toes.

C. Shoe inserts, orthopedic shoes (except when attached to a brace), arch supports and other supportive devices for the feet, are excluded regardless of the diagnosis (see Chapter 2, Section 17.4, *Orthotics*).

D. Night splints for the treatment of plantar fasciitis, e.g., heel pain.

END OF POLICY